ABSTRACT

SOCIAL WORK

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A COMPARATIVE ANALYSIS BETWEEN ADOLESCENTS OF ALCOHOLIC PARENTS WHO WERE ADMITTED INTO SUBSTANCE ABUSE TREATMENT AND ADOLESCENTS OF NON-ALCOHOLIC PARENTS NOT ADMITTED INTO SUBSTANCE ABUSE TREATMENT

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This comparative analysis examined the profile of adolescents of alcoholic parents as an identifiable group with special needs as compared to adolescents of non-alcoholic parents. The Children of Alcoholics Screen Test (C.A.S.T.), a thirty item inventory questionnaire that measured children's feelings, attitudes, perceptions, and experiences related to their parent's drinking behavior, was administered to two groups of children ages 12-17. One group was composed of adolescents admitted into a substance abuse program, who self-reported that they were adolescents of alcoholic parents. A comparison group was randomly selected from "typical" classroom settings with adolescents who had not been previously identified as adolescents of alcoholics. It was hypothesized that the children of alcoholic parents would score significantly higher on the C.A.S.T. than the comparison groups.

The major findings of this study revealed adolescents from both groups were fearful that problem drinking would result in divorce of their parents. Implications of these findings suggest an increased awareness and early identification of adolescents of

alcoholics would result in more accurate diagnosis in the school and clinical settings. Services could then be effectively designed to meet the needs of these special adolescents. If not, the effects of this disease could at some time effect a much larger population.

By researching the impact that parental alcoholism has on adolescents, prevention strategies can be instituted to identify adolescents of alcoholics early and maximize their changes for living fruitful and productive adult lives.

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CHAPTER ONE

INTRODUCTION

A surprisingly large number of adolescents in the United States experiment with mood-altering substances. These substances include a wide range of illicit and legal products such as glue, spray paint, marijuana, alcohol, cocaine, crack, heroin and tobacco. In spite of the fact that alcohol and other substances result in high incidents of accidental deaths every year, teenage substance abuse has increased dramatically.

An estimated 13.9 million Americans, 6.4 percent of the U.S. population age 12 and older, were users of illicit drugs in 1997, meaning they had used an illicit drug in the month prior to the Substance Abuse and Mental Health Services Administration survey.[1] Among young people between age 12-17 alcohol and drug use continued to increase, primarily in marijuana use, which increased from 7.1 percent in 1996 to 9.4 percent in 1997[2].

About 32 million engaged in binge drinking, meaning they had five or more drinks on one occasion on five or more days in the past month prior to this survey.[3]

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[1]R. J. Ackerman, Same House, Different Home (Pompano Beach, FL: Health Communications. 1967), 23-26.

[2]Ibid.

[3]Ibid.

There were 11 million heavy drinkers identified in this study, most of which were single males, meaning they had five or more drinks on one occasion five days prior to this survey.[4] In 1997, 11 million drinkers were aged 12 to 20 of this group, 4.8 million, or more than 40 percent, engaged in binge drinking, including 2.0 million heavy drinkers.[5]

Substance abuse and alcoholism cause major health and social problems around the world. It is thought to be the leading health problem in America. Chemical consumption not only affects the afflicted person and his or her family, but it also has an impact on all of our lives in many ways. These affects might be divorce, homicide, as well as child abuse.

In a typical American community, statistics reveal one out of six families in a neighborhood is affected by alcoholism.[6] Alcoholism is a disease that knows no distinctions. The effects of this disease could at some time affect society. Although alcoholism is treatable, it has no known cure. Many people are confused about alcoholism because there is not one specific pattern of behavior or observable trait typical to the alcoholic. Only 3 to 5% of the alcoholic people in the United States are represented by the stereotypical "Skid Row" drinker.[7] The average alcoholic is a man or woman with a family, job, and responsibilities. Black further states that the alcoholic is an individual who, in his drinking, has developed a psychological dependency on the

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[4]R. J. Ackerman, Children of Alcoholics: A Guide Book for Educators, Therapists, and Parents (Holmes Beach, FL: Learning Publications, 1983), 120-137.

[5]Ibid.

[6]Claudia Black, It Will Never Happen To Me (Denver, CO: Medical Administration Company. 1981), p. 24.

[7]Ibid.

substance alcohol along with a physiological addiction.[8] Ultimately, drinking becomes a preoccupation and compulsion and causes problems in major areas of their lives. Everyone whose life touches the alcoholic is in one way or another affected by the person's disease, but its direct consequences fall on the members of his immediate family. As one progresses into the disease it is most normal for the spouse to become increasingly preoccupied with the behavior of the alcoholic. The preoccupation, according to Black, is called co-alcoholism.[9]

For adolescents in the family, the combination of alcoholism and co-alcoholism results in neither parent being responsive and available on a consistent, predictable basis. Adolescents as products of their environment, are impacted by the family dynamics created as a consequence of alcoholism. Adolescents seem to adopt life roles by watching and modeling their parents; and when those parents are alcoholic, youngsters may have problems in healthy and normal role development.

Adolescents of alcoholics outnumber alcoholics and there are an estimated twenty-eight million adolescents of alcoholics in the United States; seven million of them are adolescents under the age of eighteen. One out of every eight Americans is the child of an alcoholic.[10] Among all adolescents, a longitudinal study revealed most all drug use

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[8]Ibid.

[9]Ibid.

[10]J. Kenney & G. Leaton, Loosening The Grip (St Louis: C. V. Mosby Company. 1978), p. 94-96.

begins in the preteen and teenage years.[11] These years are few in the total life cycle, but critical in the maturation process.

During this intense period of adolescent growth, conflict is inevitable and the temptation to use drugs is great. With drugs readily available, adolescents,12-17, are curious and vulnerable, there is peer pressure to experiment, and there is the temptation to escape from conflict. A crucial part of their development is the adolescent's ability to discern what feels good to him or her and what does not. The adolescent who has grown up in a chemically dependent family system often lacks this important ability to circumspectly recognize what he or she is feeling.

Alcoholism is considered a generational disease. It has been shown to run in families although the exact cause of this phenomena is not yet known.[12] Is alcoholism transmitted from one generation to the next? If so, how? Are the adolescents of alcoholics at greater risk to become future alcoholics than other adolescents? These are primary issues in the literature which reveals numerous methodologies and findings but few conclusions about how and why the transmission of alcoholism occurs. The relationship of heredity and environment is so inextricably tangled that it has not yet been possible to weed out the primary cause.[13]

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[11]R.J. Ackerman, Children of Alcoholics: A Guide Book for Educators Therapists, and Parents (Holmes Beach, FL: Learning Publications, 1963), p. 246-259.

[12]C. Janzen, "Families in the Treatment of Alcoholism" Journal of Studies on Alcohol 38 (1977): 114-130.

[13]R.M. Cork, The Forgotten Children (Ontario, Canada: Addiction Research Foundation, Inc. 1969), p. 15.

While it is probable that certain genetic pre-dispositions for alcoholism exist, it is also likely the quality of life in an alcoholic home may contribute to future alcoholism. Studies reveal adolescents of alcoholics are the highest at-risk four times as high as the danger for the rest of the population group expected to find substantial problems, even if the detrimental effects of having an alcoholic parent were minor and short term.[14] It is now believed that the effects stemming from parental alcoholism are significant and occur throughout the life span of a child.

Although adolescents of alcoholics come in all sizes, shapes, colors and ages, common bonds appear that each individual has learned a strategy or coping style. Many have taken on certain identifiable roles to survive the alcoholism that affects their family system. These roles serve to keep the family functioning in a system of denial while enabling the alcoholic to continue his drinking.

Statement of the Problem

The impact of alcoholism's impact on adolescents presents a problem. Each year 3,700 to 7,400 U.S. babies are born with Fetal Alcohol Syndrome caused by maternal drinking of alcohol, resulting in growth deficiency, mental retardation, facial abnormalities and birth defects. Alcoholism typically represents a progressive sequence of events that may continue through several phases of the life cycle. If drinking begins in an more early developmental phase, dysfunction may be obvious, or it may remain more insidious, and create consequences. An additional 11,000 to 18,500 babies are born other

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[14]Ibid.

birth defects. An additional 11,000 to 18,500 babies effects.[15] The annual cost to the nation of treating these adolescents under the age of 18 is $670 million.[16]

Adolescents of alcoholics may have physical and emotional problems, or inappropriate age related role responsibilities. Teachers report that adolescents of alcoholics are more likely to be hyperactive or delinquent. They often have difficulty concentrating or forming trusting relationships.

These adolescents are twice as likely to have psychiatric treatment for conduct disorders, anxiety or depressive symptoms or to abuse alcohol and other drugs.[17] These adolescents are three times more likely to be expelled from school, or drop out due to early marriage, pregnancy, institutionalization, or military enlistment. Some teenagers of alcoholics appear more resilient and are top-ranking "mini-adults" who perform all functions well, but seem to experience no personal satisfaction in their successes. Recent studies have found a relationship among adolescents of alcoholics and eating disorders, and increased teenage suicide.

In recent years, there has been progress in the consideration of alcoholism as a family disease, but adolescents are generally viewed as part of that total structure rather than as individuals having special problems and needs unrelated to the family. Although there is no prototype to describe the quality of life in an alcoholic home, Wegscheider

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[15]S. Wegscheider, Another Chance: Hope and Health For The Alcoholic Family (Palo Alto, CA: Science and Behavior Books. 1981), p. 234-245.

[16]Ibid.

[17]Ibid.

developed the concept of alcoholism as a family disease with each family member playing a particular role, and Claudia Black has identified distinctive psycho-social characteristics that are adopted to help the adolescent cope or survive within the alcoholic family system.

Yet, whatever roles adolescents adopt there are gaps emotional or psychological voids which occur as the result of unpredictable and inconsistent parenting in alcoholic homes in their development and growth. The adoption of a particular role of an adolescent is not calculated behavior. It happens subconsciously, and a family member is likely to deny that the role exists. Although many of these roles are seen in healthy families, especially in times of stress, in alcoholic families the roles are more rigidly fixed and are played with greater intensity, compulsion, and delusion.

Currently, there is a growing awareness reflected in the literature and in the arena of self-help and treatment groups that is crucial to the understanding of how parental alcoholism damages adolescents and heightens their risk for a variety of unhealthy patterns and illnesses. Increased awareness and early identification should result in more accurate diagnoses in the schools and clinical settings. Services could then be effectively designed to meet the needs of this special population. If not, the effects of the disease could at some time effect us all.

Significance and Purpose of the Study

There is no particular type of clinical social worker nor any single agency totally responsible for helping adolescents of alcoholics. Social workers in the alcoholism field

are increasingly recognizing the need for becoming more skilled in working with adolescents of alcoholics. However, it has been estimated that only five percent of the 12 to 15 million school-aged adolescents of alcoholics are identified and treated.[18]

Many of these adolescents are still invisible to the social worker. Those who have come to a social worker's attention usually are those who are acting out their problems, not the many adolescents who are adjusting. It is important that social workers and anyone who works in areas where they come into contact with adolescents begin identifying the many adolescents of alcoholics in their settings so that they can receive help.

Discovering these at-risk adolescents would sensitize clinicians to the high incidence of problems, confusion, and worry that some teenagers may be experiencing. Early identification could lead to their proper referral and treatment. This detection could prevent further problems, such as hospitalizations for psychosomatic illnesses, school behavioral and scholastic difficulties, emotional identity, substance abuse problems, etc., from developing in the lives of the adolescents.[19]

Screening opportunities should be everywhere that clinicians practice. For whatever reasons an adolescent comes to or is referred for help, there is little chance of success unless the problem is recognized as a symptom of a larger disorder. Thus, there is a need to develop an understanding of what alcoholism is, acknowledge the existence

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[18]J. Rimmer, "The Children of Alcoholics: An Exploratory Study" Children and Youth Services Review (1982), 365.

[19]J. Jackson, The Adjustment of the Family to The Crisis of Alcoholism (New York: National Council on Alcoholism. 1954), p. 11.

of the population at risk, and develop an understanding of the background of the thoughts and feelings an adolescent may be experiencing as a consequence of his family situation.

Adolescents of alcoholic homes seldom learn the combination of roles which mold healthy personalities. They have played their roles to survive. It may be up to professionals to recognize the symptoms and know what they may imply. Suspecting alcoholism presents the professional with a delicate situation. There is not always conclusive evidence to confirm suspicions, nor can honest admission from an adolescent be counted on. Resource people should never underestimate the amount of difference they can make in the life of an adolescent of alcoholic no matter how hopeless the situation may appear.

Adolescents of alcoholics grow up never having shared their closest thoughts or feelings. Becoming a resource to the teen is perhaps the first step in treatment for both the child and his family. Social workers are in a unique position to recognize family problems, learn to identify alcohol abuse, provide protection, and connect adolescents with other resources.

Adolescents must believe that a resource has something to offer, will be there and can be counted on when needed. If a resource is only patronizing, stigmatizing or ineffective, the child will not return for help. The more learned about alcoholism, the easier it is to discuss difficult problems easily and openly and hopefully be perceived as a reliable resources to adolescents so they will be able to take the risk of talking about their problems. Many times one may not be in a position to help change the home situation,

but can be a vital source in helping the teenager withstand the pressures and confusion in their alcoholic family.

Teenagers are rarely aware of the availability of resources or they feel immobilized or powerlessness to act on their own. An adolescent is more likely to follow through with a program or referral when it is a trusted person who suggests participation. Adolescents of alcoholics have suffered unhealthy consequences due to the lack of involvement with other people not from concerned involvement. Considering the numbers of potential alcoholics living in alcoholic families, there should be ample motivation for society to try and stop the cycle. The purpose of this research paper is to determine the significance of adolescents of alcoholics as an identifiable group with special needs, to show that they have taken on certain roles, and each has learned a strategy or coping style to survive the alcoholism that affects their family system.

By seeking to determine the significance of alcoholism on the offspring of alcoholics, social workers may help prevent future adolescent of alcoholics from actualizing his risk potential of becoming an alcoholic and we may be able to help reshape their old roles, that were adopted to maintain the dysfunctional family system, and help them learn new roles.

CHAPTER TWO

REVIEW OF THE LITERATURE

Toxic family systems may be exacerbated by an alcoholic family member can have a profound impact on teenage children being reared in this system. The manifestation of salient emotional and psychological disturbances adolescents of alcoholics carry for many years do not typically become apparent to healthcare professionals until they enter secondary school, due primarily to their remarkable resiliency and adaptation.

Upon entering school or other organizations where these problems are more pronounced, and these adolescents of alcoholics have to interact interpersonally with same-age peers, they frequently demonstrate an inability to have fun, delay immediate gratification, attempt not to control others interactions, or be the person "in charge," runaway from home, entertain thoughts of suicide, displace their anger onto others, and struggle with depression.

Adolescents of alcoholics are admitted to mental health and substance abuse programs for behavioral problems in school, family discordance, and as desperate attempts to manipulate the alcoholic parent into treatment. They generally do not have any knowledge or understanding of alcoholism but know that the alcoholic parent's behavior is tearing the family apart.

Related Research

Responsible child, adjuster, placater and acting-out child are roles seen in healthy families especially in times of stress, in alcoholic families these roles are more rigidly fixed and are played with greater intensity, compulsion, and delusion. Each role grows out of its own payoffs for both the individual and the family. Which role is played by which person appears to be related more to position in the family than to personality factors. The plight of the only adolescent in an alcoholic family is that the adolescent may take on parts of all the roles.

Co-dependency is referred to any spouse of an alcoholic. Claudia Black states that the adolescent of an alcoholic is affected not only by the alcoholic, but also by the co-alcoholic and the abnormal dynamics that are a consequence of the alcoholism. She describes adolescents of alcoholics as fitting into one or more of four roles: the responsible one, the adjuster, the placater, and the acting out child. Whatever roles adolescents adopt, there are developmental gaps that are related to issues of control, trust, dependency, identity, and expression of feelings. These factors will eventually affect relationships in childhood, adulthood, particularly intimate ones, and may contribute to depression, continuance in a dysfunctional system via marriage, and perhaps their own substance abuse.[1] Researchers have recently began to pay particular attention to adolescents, despite having abundance of information about children of alcoholics growing up in alcoholic families.

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[1]Claudia Black, It Will Never Happen To Me (Denver, CO: Medical Administration Company. 1981), p. 29-30.

Although alcoholism has existed for thousands of years, researchers are just beginning to understand, accept and assist alcoholics. While the National Institute on Alcoholism found that over 9.3 to 10 million alcoholics in the United States and between twenty-five and twenty-eight million adolescents of alcoholics have been identified in our society, it is only recently that researchers have begun to assess the magnitude of alcoholism and the problems of being an alcoholic.[2] The question of whether alcoholism is a disease, a symptom of an underlying illness, or a condition one brings on by choice has been studied extensively. The major development in the alcohol field during the last decade is the increased attention to the plight of the alcoholic's family although formal research on the effects of alcoholism on the family is still new.[3]

While no definite answers have been agreed upon by researchers as to the causes of alcoholism, most do agree that alcoholism is a disease, often called the family disease. The American Medical Association defined alcoholism as a disease in 1957. The United States Government has passed legislation which requires the treatment of alcoholism as a disease and recognized it as the third leading health problem in the country.

Since the turn of the century, the alcoholic has been the subject of much writing and research. The spouse and teenagers growing up in alcoholic homes have been largely ignored, although they are a population at risk for many problems, much unhappiness and

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[2]J. Flanzer, Alcohol Abusing Parents and Their Battered Adolescents (Texas: Currents Alcoholism, 1979), 529-539.

[3]J. Kinney & G. Leaton, Loosening The Grip (St. Louis: C.V. Mosby Company. 1978), p. 4-5.

the strong possibility of becoming future alcoholics themselves.[4] Traditionally, the focus was on the active alcoholic and perhaps, the sober spouse as well. The adolescent's problems were seen as self-limiting, able to vanish as the teen grew up, or seen as a useful kind of adversity. In recent years, there has been more consideration of alcoholism as a family disease, but adolescents are generally viewed as part of that total structure rather than as individuals having special problems and needs.

Until the advent of family systems theory, teenagers of alcoholics received practically no attention. Alcoholism treatment programs were focusing more on a family systems approach. Yet, alcohol programs treat only a small percentage of alcoholics, so the number of adolescents who get service is limited to those whose parents are in treatment. Many treatment programs use adults as prototype patients although the use of certain techniques that would be successful with adults are not so with adolescents. Adolescents needs are different from thoughts of their parents. They must be able to effectively focus on their own guilt, anger, fear, loneliness, and denial without the stifling influence of a parent's presence.[5]

Support groups for adolescents of alcoholics are being developed and conducted by many schools. While the primary role and responsibility of the schools is education, in order to educate, they need information about signs and symptoms of substance abuse and characteristics of adolescents who may be living in an alcoholic family. The National Association for Children of Alcoholics was formed by an interdisciplinary team

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[4]Claudia Black, It Will Never Happen To Me (Denver, CO: Medical Administration Company. 1981), p. 87-93.

[5]J. Greenleaf, Co-Dependence An Emerging Issue (Pompano Beach: Health Communications. 1984), p. 23-24.

of therapists, teachers, authors, and physicians who wished to serve as a network for co-dependents seeking support and help in the area of adolescent of alcoholics. This organization also offers programs that can be instituted in the schools. Currently, services for adolescents of alcoholics are limited, and the public is generally unaware of these teenager's needs.

In the past five years there has been a tremendous increase in attention given to the alcoholic's family, especially the teenager, as evidenced by the plethora of books, professional and lay articles in journals and magazines, famous people's self-disclosures, and the burgeoning growth of support and treatment groups for adolescents of alcoholic parents. Yet because of the societal uncertainty surrounding alcoholism, most adolescents of alcoholics have not openly shared their experiences or received help.

It is the researcher's opinion that more effort has gone into covering up the problems than into seeking help, thus the adolescents themselves have contributed to their being unnoticed. Through unique screening programs available to all the children, even the ones who would never ask for help, resource people without any prior background in alcohol treatment or psychology, will be able to help and identify adolescents of alcoholics.[6]

According to Ackerman, co-founder of the National Association for Children of Alcoholics, only five percent of adolescents of alcoholics are in treatment specifically for those problems that arise from being a child of an alcoholic. Estimates indicate a high percent of the juvenile courts caseloads, child guidance clinic referrals, school discipline

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[6]Claudia Black, It Will Never Happen To Me (Denver, CO: Medical Administration Company. 1981), p. 36-41.

problems and those symptoms that bring adolescents to the medical profession are adolescents who come from alcoholic homes.[7]

Due to each family's individuality, there is no prototype to describe the quality of life in an alcoholic home.[8] However, there are some common themes which do exist. While not all families experience all the same characteristics many do not share typical patterns. A brief description, concluded from a review of the current literature on adolescents of alcoholics, on some the problems adolescents encounter in living with an alcoholic parent serves to identify these individuals as a special population.

Whereas the adolescent may see the relationship between drinking and resulting drunken behavior, they do not understand the sober parents' behavior. Adolescents are often angry at the non-drinking parent for not protecting them from the alcoholic or not getting them another better parent. They learn early on not to expect anything because they do not deserve it or that people will disappoint them, anyway.

Consequently, adolescents try to gain some control over their lives while reacting with anger and deep hurt to their home situations. The adolescent described continual tension and anger at home, strained relationships with siblings, rage and defiance directed at adults and an inability to have comfortable relationships with friends.

Morehouse indicates that adolescents of alcoholics often feel guilty and feel that if their own behavior were better, the drinking would not happen.[9] They also equate

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[7]Ibid.

[8]R.J. Ackerman, Children of Alcoholic: A Guide Book for Educators, Therapists and Parents (Holmes Beach, FL: Learning Publications, 1983), p. 132-141.

[9]Ellen, R. Morehouse, Preventing Alcohol Problems Through A Student Assistance Program (Rockville, MD: NIAAA. 1984), p. 10.

drinking with not being loved and cannot understand why a parent who cares for them would continuously hurt them by breaking promises or giving them inadequate attention or affection. Adolescents are particularly confused by different types of drinking behavior, daily drinking, episodic patterns, dry for long intervals between binges, consumption of large quantities of alcohol, some limited to beer, some wine, and fear that the alcoholic parent will become ill or die. Adolescents have unique problems when alcoholic parents have blackouts or hallucinations.

It is suggested by Greenleaf that the alcoholic person has the disease and the family members have the alcoholism syndrome.[10] He develops the terms co-alcoholic and para-alcoholic within the alcoholism syndrome. The prefix "co" means "with or necessary for the functioning of" and therefore the co-alcoholic is the adult who assists in maintaining the social and economic equilibrium of the alcoholic person. The prefix "para" means "like or resembling." The adolescent growing up in the family with the alcoholism syndrome is therefore like or resembling both the alcoholic and the co-alcoholic and is called para-alcoholic. Greenleaf develops differing etiologies for para-alcoholics and co-alcoholics which are related to volition and mobility in that adolescents have neither the choice to enter or exit, nor the mobility to exit from the relationship.[11] The adult may feel trapped but the adolescent is trapped.

Co-dependency can emerge from any family where certain unwritten, even unspoken, rules exist. Co-dependency is defined as a dysfunctional pattern of living and

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[10]J. Greenleaf, Co-Dependence An Emerging Issue (Pompano Beach: Health Communications. 1984), p. 16-17.

[11]Ibid.

problem-solving which is nurtured by a set of rules within the family systems and people with co-dependency handle stress and conflict by the rules they internalize in childhood.

Throughout the literature review, alcoholism is perceived by the adolescent in an alcoholic family as the "biggest secret of all." The rule of secrecy and denial in alcoholic families is very tight. Adolescents living in an alcoholic home do not usually turn to outsiders for help. Typically parents transmit the message that the family secret cannot be shared with anyone. This need to guard the family secret keeps adolescents from alcoholic homes isolated from other teenagers, inhibiting their ability to make friends, relax, or experience usual adolescent fun and good experiences. They are usually fearful of trusting others or becoming close to anyone. Adolescent of alcoholic parents seem to have a harder time with intimacy. In describing themselves adolescents between 12-17 from alcoholic homes said they were: "Ugly, no one, stupid, hated, unlucky, pressured, disappointed often, betrayed and depressed."[12]

Some indicators or rules of a working healthy family versus an alcoholic family, that provide good background information for those who may come in contact with an adolescent in an alcoholic family, are consistency vs. inconsistency, emotions openly expressed and shared vs. repressed and un-shared emotions, a nonjudgmental environment vs. a judgmental and blameful environment, a consistent value system vs. a chaotic value system, support and attention vs. silence, trust love vs. jealousy and

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[12]J. Greenleaf, Co-Alcoholic Para-Alcoholic (Los Angeles, CA: Jael Greenleaf. 1981), p. 78-79.

suspicion, family rules that lead to healthy functioning and interaction vs. rules built on shame, guilt, fear, unspoken expectations, and the silent rule of don't tell.[13]

When trying to identify or work with adolescents of alcoholics, these are some of the myths working behind the scenes in the minds of most adolescents of alcoholic:[14]

1. "I caused the alcoholism - I should do something about it". This is probably the most widely held myth and the one to which adolescent cling to most fervently. It is the base on which guilt, blame, and struggles for autonomy lie. It leads to frustration and helplessness.

2. "I'm not like anyone else." Adolescents who have lived with alcoholism feel their families are different even though they may not know in what respect. They feel different themselves or feel set aside by significant others.

3. "I have to be in control of myself and everything else of my world will fall apart." For adolescents of alcoholics fantasy makes the feeling of being out of control go away and it feels good and safe, at least temporarily.

4. "Someone will come along or something will happen that will change all this." A fairy godmother will wave her wand. This myth, unlike the others, offers hope, although in reality it does little to make things better.

The power behind these myths varies from individual to individual but most adolescents experience each of them at one time or another. Developing an understanding of the background of the thoughts and feelings an adolescent may be

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[13]R. Subby, Lost In The Shuffle (Pompano Beach, FL: Health Communications, 1987), p. 23.

[14]J.S. Seixas & G. Youcha, Children of Alcoholism A Survivor's Manual (New York: Crown Publishers. 1985), p. 176-177.

experiencing as a consequence of his/her family situation allows professionals or individuals who come into contact with adolescents to become prime resources for adolescents of alcoholics.

Alcoholism almost always interferes with the "normal" development and parenting of adolescents. Piaget, Freud, Skinner, Maslow, Mead and Sullivan in their studies all analyze the human development of children.[15] Constant to these various models in the analysis of human development from the perspective of a "normal" or "ideal" type with normal patterns or stages of development serving a model. In the case of adolescents of alcoholics, levels of development may not always be normal.

Yesterday's permitted behavior is today's prohibition and the rules are always changing. Similarly, adolescents cannot comprehend the dichotomies in their parent's personalities. The adolescent never knows who he/she is addressing the good parent or the bad parent.

Further, adolescents cannot understand how a parent can be physically and emotionally absent. Adolescents have reported that the parent is not there, out to lunch, "spaced out," AWOL," "on the road."[16] They do not realize that many emotional reactions and inconsistencies are the result of fluctuations in their parent's blood alcohol level. Behavior caused by physiology is often experienced by adolescents of alcoholics as deliberately cruel.

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[15]R. Shuster, The Process of Human Development (Boston/Toronto: Little, Brown & Company. 1986), p. 29.

[16]Ibid.

The Minnesota treatment program for families found linkage between incest and alcoholism. It also reports that where there is sexual abuse of adolescents and in at least half its cases the abuser has an alcohol problem. Studies about the link between alcoholic parents and adolescent abuse are more numerous but conclusions tend to be somewhat contradictory.[17]

Preliminary results of a study by Mayer on the relationship of child abuse, neglect, and alcoholism, indicated that some alcoholic parents successfully limited their drinking to times when they were not responsible for care of their children.[18] Deliberate decisions were made not to discipline their children when drinking, and patterns of control were attempted. The study also illustrated inter-generational aspects of child abuse and alcoholism. Many of the 100 alcoholics in the study were themselves adolescents of alcoholic parents, and several reported being abused as children.

A 1971 study by the Massachusetts Society for the Prevention of Cruelty of Children reported that 34.4% of child abuse cases also involved alcohol. Emerging trends form a study of abused and neglected adolescents aged 12-17 whose parents abused alcohol, the greater the alcohol abuse, the greater the physical abuse or neglect. These findings and more are pointing to linkages between alcoholic parents and child abuse.[19]

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[17]J. Mayer & R. Black, "The Relationship Between Alcoholism and Child Abuse and Neglect" 4 Currents In Alcoholism, (1977): 429-444.

[18]Ibid.

[19]Ibid.

This brief description of some of the problems adolescents perceive and encounter in living with an alcoholic parent serves to identify these individuals as a special population. Recognizing one of the major roadblocks to understanding, diagnosing, and treating co-dependency has been the lack of a generally accepted definition or diagnosis.

Professional organizations are advocating the recognition of a diagnosis of Co-dependent Personality disorder, to be included in the DSM IV under the framework of Mixed Personality Disorder, a condition that exists when an individual does not qualify for a single Personality Disorder diagnosis but has marked traits of several of the Personality Disorders.

Theoretical Orientation

Researchers continue to argue whether the disease of alcoholism is inherited or the result of learned behavior. Research into the idea that a person's environment is an accurate predictor of alcoholism is plentiful. Abuse of alcohol is a learned response established by continual practice, where as, drinking can become a preferred way of handling a problem.[20] Adolescents of alcoholics are thought to become alcoholic because of a neglected home environment, role modeling by parents of excessive drinking habits, parents who make their adolescents overly anxious, causing the adolescent to turn to drinking to reduce that anxiety, and learning that certain problems can be dealt with by drinking. Whether it is environmental or heredity factors or a combination at predisposes

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[20]T.L. Cermak, Diagnosis and Treatment Co-Dependency (Minneapolis: Johnson Institute Books. 1986), p. 22-24.

a person to alcoholism makes no difference the fact is that it does run in families and an adolescents is at high risk by coming from a family with a history of alcoholism. Alcoholism causes the family unit to live in a dysfunctional way and thus it is labeled "the family disease."[21]

In an effort to explain the development of the disease called alcoholism, researchers have concentrated their efforts in three main areas. These are the physiological, the body itself, psychological, the mind, and social or cultural environment[22]. The physiological studies include research into physical factors in the body, liver function, blood groupings, sex type, color blindness, abnormalities of the brain, allergy reactions, or genetic causes which might predispose an individual to develop a disease state through the use of alcohol. In order to try and separate an inherited predisposition for alcoholism from environmental factors, studies involving identical and fraternal twins separated soon after birth and reared by separated parents have pointed to a genetic factor, although this factor has not yet been isolated.[23]

Adopted studies conclude that the major determinant for alcoholism in the adolescent was the presence of alcoholism in the biological parent rather than environmental influence.[24] This, however, is not considered conclusive evidence that

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[21]L. Kaij, Alcoholism in Twins: Studies On The Etiology and Sequels Of Abuse of Alcohol (University of Lund, Sweden: Department of Psychiatry. 1960), p. 243-249.

[22]Ibid.

[23]Ibid.

[24]N.J. Estes, Nursing Diagnosis of the Alcoholic Person. (St. Louis: The C.V. Mosley Company. 1980), p. 11-12.

shows alcoholism is inherited. The psychological researchers are exploring how individuals use alcohol as a tension reducer, an escape from emotional stress with anxiety being the most prominent psychological factor associated with the illness alcoholism.

The social and cultural researchers are looking at the social setting in which one learns to drink and he cultural attitudes centering on the use of alcohol. Some researchers have suggested certain cultures have use of alcohol as a means of solving problems. Others are trying to show the family predisposes its members to alcohol abuse by improper role modeling.[25]

Alcoholism is a progressive family disease and, if left untreated, can dissolve the family unit. Years ago, the literature reflected a moralistic view with the alcoholic depicted as an incorrigible "louse" and with help efforts directed to the wife and adolescents who were seen as innocent victims.[26] With the advent of psychoanalytic theory, both the alcoholic and the spouse were viewed as victims, each having definite personality traits which contributed to the illness.[27] There is research that refutes the disturbed personality theory.

Sociologists took issue with the psychoanalysts. They proposed a stress theory in which the spouses personality characteristics came as a result of the stress theory. The family systems theory in the 60's had tremendous implications for the disease concept of alcoholism. The stress theory assigned the problem to the alcoholic and the systems

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[25]Ibid.

[26]Ibid.

[27]T.L. Cermak, Diagnosis and Treatment Co-Dependency (Minneapolis: Johnson Institute Books. 1986), p. 245-247.

theory assigned it to the family, placing blame on neither the spouse nor the alcoholic. According to Estes, Systems Theory emphasizes that family units need to function smoothly. When something interferes with that functioning, the family struggles to re-establish homeostasis. The striving for homeostasis can lead to behaviors that resist change over long periods of time. In the context of the alcoholic person and his family, excessive drinking behavior, once established, becomes part of the status quo.

The alcoholism is often unwittingly perpetuated by the behavior of family members. At the same time, systems theory emphasizes that it is possible for growth-producing change to occur within the family unit when members learn to make affirmative alterations in their response. Since the late 1960's family therapy has become a popular and accepted treatment modality for alcoholism, and there is a sizable body of literature describing various approaches.[28]

Although the entire family unit is the primary client, most of the literature is focused on adult interaction and the adolescents of alcoholics are usually adjuncts. While the cited researchers are related to adults adolescents of alcoholics have different treatment needs than adults. There is a growing conviction that if they can get support and perspective on what is happening while it is happening during their development, these younger victims of parental alcoholism may not need to get stuck in self-defeating patterns or roles.[29]

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[28]R.J. Ackerman, Children of Alcoholics: Aguide Book for Educators, Therapists, and Parents (Holmes, Beach, FL: Learning Publications. 1983), p. 13-16.

[29]Ibid.

Whereas general systems theory is a very viable method of studying the family, the developmental theory approach in studying adolescents of alcoholics' development versus adolescents of alcoholics, will be used as this researcher's frame of analysis.[30] Erik Erikson offers a proactive, universal approach to affective development. The affective domain encompasses all the emotional aspects of self- feelings, longings, values, motivations, aspirations, commitments, frustrations, restraints, and identifications. In short, affective domain is concerned with internal responses to external events, other people, and one's basic attitude toward life. Erikson's frame of reference is useful and flexible both in assessing clients and in establishing a supportive milieu. He proposes that personality development is a lifelong experiencing process and environment plays a major role.[31]

Inadequately supportive environments impede progress or complete resolution of earlier stages of development. His eight psycho-social developmental levels have specific tasks for positive growth that need to develop. A specific age is not attached to these developmental levels, since each person progresses at his/her own rate. Both genetic and environmental factors can influence the rapidity with which one progresses through the stages.

Developmental theory is a blend of biological and environmental influences and their interactions. It is the researcher's opinion that adolescents of alcoholics are apt to

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[30]Ibid.

[31]E. Erikson, Youth Changes and Challenges (Double Day New York: Publish 1963), p.16-18.

encounter developmental aspects with environmental implications different from those met by the adolescent of non-alcoholic parents. Some may have detrimental effects, others may not, for each child's development is unique and dependent upon a building-block theory of internalizing experiences.

Erikson's concepts are based more upon society's effect on a person rather than the person's effect on society. Adolescents of alcoholics are often overwhelmed by their environment and have little chance to act upon it. At each stage of development Erikson sees particular conflicts that must be resolved in a positive manner. The success or failure of this resolution affect the handling of conflicts at future stages. As time passes, the adolescent begins to establish a collection of positive and/or negative outcomes. If outcomes are mostly positive, the teenager will be better able to handle later adult roles.

Erikson saw a sense of trust as the most vital element of a healthy personality[32]. Formation of trust begins at birth and is crucial during the first year of life when the infant is completely dependent on the fulfillment of basic needs. Maternal deprivation by an alcoholic mother can undermine the establishment of an infant's trust. Even in cases where a baby's physical needs are satisfied, trust may not be established because of lack of emotional stability. The seriousness of alcoholic parental role - inconsistency is underestimated at this level feels that without a basic sense of trust in infancy the crises of late stages will be difficult to handle. When parental alcoholism occurs at later stages in

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[32]Ibid.

a child's development and a sense of trust has been developed, the adolescent may be better able to hand the onset of alcoholism in a parent.[33]

During the second stage of development, autonomy versus shame and doubt, a parent who wants to protect his/her child from the home environment may unwittingly limit childhood growth. The adolescent may be denied the opportunity to develop a sense of self-control because all forms of control, usually administered through restrictions, are supplied. The adolescent may not be able to develop sufficient autonomy resulting in a self-concept of inadequacy and shame.[34]

In the third stage of psycho-social development, conflicts between initiative and guilt feelings begin in a four or five-year-old child, when his/her curiosity about the world is treated as inappropriate or ignored. Normal playful games and activities may be stopped short or prohibited by parental commands thus caused feelings of guilt in the teenager. Inconsistency does more harm than being too restrictive and in alcoholic homes inconsistency is a dominating factor. To overcome this the adolescent may choose to over-conform, at the expense of subjugating initiative and creativity. This stage is also characterized by observation and imitating of adult behavior. Role modeling, when performed by an alcoholic, can give an adolescent inappropriate concepts of adult roles. the adolescent sees alcoholism as an integral part of the role being played by either or both parents.[35]

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[33]Ibid.

[34]Ibid.

[35]Ibid.

The typical adolescent entering middle school begins to develop a need to feel useful, commensurate with his/her ability to explore and achieve. This is what Erikson calls a "sense of industry." A crisis at this stage occurs if a sense of inadequacy or inferiority becomes dominant over the sense of industry.[36] Although problems at this period are mostly concerned with school environment, a lack of parental interest in the teenager's accomplishments can compound the child's sense of inferiority and feelings of uselessness can emerge. Survival in school - the adolescent's first step outside the primary environment, can depend upon the amount of self-esteem the adolescent has developed within the home, plus the amount of support provided by parents when the adolescent encounters school problems. Alcoholic parents may value education highly, but because of drinking, guilt, and stress, they may be unable to provide the guidance necessary to help their adolescent succeed in school.

The fifth stage of learning identity versus identity diffusion is closely related to development during adolescence. Over-identification with negative characteristics is a problem that can occur at this stage. In alcoholic families negative feelings and rebellious actions are often present because the entire family may feel or act deviant, making it more than normally difficult for the teenager to search for individual identity. A sense of personal identity may be overshadowed by family identity.[37]

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[36]Ibid.

[37]Ibid.

The intimacy versus isolation stage is concerned with the ability to establish intimate relations with others.[38] The ability to establish primary relations with others may be the single most important consideration for adolescents of alcoholics. Adolescents who emerge emotionally affected from an alcoholic home may find themselves socially isolated. They have not had the opportunity to develop the life skills necessary to become fully functioning adults and may be forced to remain within themselves.

The effects of parental alcoholism do not disappear when the adolescent leaves the home. Once patterns have been established they may continue throughout adulthood. In the generativity versus self-absorption stage when the adult should have positive qualities to pass on to future generations, some adults have become parents who have little to offer their own teenagers. They may have been deprived of learning how to form interactions with others therefore are paralyzed in relationships with their own adolescents. Surviving an alcoholic home may have taken all the teenager had, so that in later life there is nothing left to give. This is a serious problem because adolescents of alcoholics can become alcoholics themselves and the process is continued.

Erikson's last stage is development of integrity in the adult.[39] Unless adolescents of alcoholics are able to achieve success at the previous life stages, this last stage which involves acceptance of responsibility for one's own life without blaming others, appears to be impossible to attain. When integrity is not developed, the individual finds it hard to accept life as it is and may remain immature and dependent.

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[38]Ibid.

[39]Ibid.

Unless substitute environmental situations can attempt to counteract the disorganization and uncertainty of the home and family life of an adolescent of an alcoholic and unless new behaviors can be learned and old roles reshaped, many adolescents of alcoholic parents will be come alcoholic themselves and the cyclical process will continue to gain victims.

In general, life with an alcoholic parent can be characterized by fear, tension, insecurity, conflict, anger, and guilt. An adolescent simply never knows what to expect. Cork interviewed 115 adolescents of alcoholics who identified ways they felt emotionally damaged by parental drinking. Almost every adolescent said their relationships both at home and outside were affected. They felt unloved and rejected by one or both parents, were unsure of themselves, lacking in self-confidence, generally anxious and afraid of the future. They were particularly resentful of neglect by the sober parent who they perceived as ignoring them to attend to the alcoholic. They felt deeply affected by parental conflict and quarreling. Adolescents could not understand the role of the sober parent who also seemed to act crazy by reacting more to the alcoholic, ignoring the adolescent and unable to give them any support or protection.[40]

When a parent makes a promise during a blackout, there is not future recollection of the commitment. Since adolescents do not know about the physical phenomena of blackouts, they do not realize their parent was unaware of making or breaking a promise. Hallucinations, too, can be extremely disturbing. A young child, exposed to parental

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[40]M.E. Chafetz, "Children of Alcoholics" New York University Education Quarterly 3 (1979): 23-39.

delusions, may believe his parent is actually going crazy. Adolescents often experience cognitive confusion because their world is not similar to the real world, and it is hard for them to distinguish the differences. They cannot tell if the alcoholic parent is lying or making excuses. They do not know whether to believe the parent or not. Which is the real you? The drunk you or the sober you? Adolescents are disappointed when parents fail to show up for school functions.[41] Inconsistency is a constant of life with an alcoholic parent. Their unpredictable behavior, combined with the social stigma of alcoholism, often inhibits adolescents from bringing friends home or having close peer relationships. The secret burden of having an alcoholic parent is shown to interfere with school performance, positive self-concept, development of trust and security.[42] Reportedly, adolescents generally see themselves as the cause of parental drinking. They feel responsible for their parent's drinking. They feel that they are the only ones in this situation whose parent drinks too much. By knowing little about the disease concept of alcoholism, the adolescent feels he or she can cure their parent's drinking.

The common bond amongst adolescents of alcoholics is that each adolescent has learned a strategy or coping style and taken on certain identifiable roles, not consciously, to survive the alcoholism that affects their family system. When the roles and behaviors are better understood and can be identified as symptoms of bigger problems, they can also be used as a therapeutic technique. Through behavioral therapy, one assumes that as

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[41]Ibid.

[42]Ibid.

a role has been learned, it can also be changed. Recovery for adolescents of alcoholics can be dramatic and seen in terms of the adolescent's behavior when coping replaces escaping and when their old roles, that were once rewarding and used to maintain the dysfunctional family, are reshaped.

Wegscheider, who seems to give the most comprehensive overview of family and co-dependent issues, agrees with the concept of alcoholism as a family disease with each family member playing a particular role.[43] The roles are the dependent, the enabler, the hero, the scapegoat, the mascot and the lost child. Satir, a pioneer in family systems theory, influenced Wegscheider as the physical, emotional, social, mental, and spiritual potential of each role is developed. These roles might give the adolescent who fill them a temporary feeling of control or safety, but the roles may reach a point, especially in adulthood, where they eventually stop paying off. What seemed like the solution to the childhood problem becomes in adulthood, a problem in itself. These roles in childhood serve to keep the family functioning in a system of denial while enabling the alcoholic to continue drinking and the child to survive.

Definition of Terms

Addiction:

A behavioral pattern of compulsive drug use, characterized by overwhelming involvement with the use of a drug, the securing of its supply, and a high tendency to relapse after withdrawal. Addiction always implies psychological dependence, but it is

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[43]S. Wegscheider, Another Chance: Hope and Health For the Alcoholic Family (Palo Alto, CA: Science and Behavior Books. 1981), p. 233-236.

possible to be addicted without being physically dependent.

Adolescence:

In this study adolescence is defined as youth 12 to 17 years of age.

Alcohol:

Alcohol is a central nervous system depressant and is the most widely-used and abused drug in the United States today. It is usually consumed in the form of beer, liquor, or wine.

Acloholic:

Anyone whose drinking causes a continuing problem in any aspect of his or her life and overtime has developed a physical and/or psychological dependence on alcohol and whose drinking is out of control.

Adolescents of Alcoholics:

Adolescents who are reared in a home where a parent is an alcoholic.

Co-dependence:

Co-dependence is a recognizable pattern of personality traits, predictably found within most members of chemically dependent families, which are capable of creating sufficient dysfunction in social, psychological, emotional, and occupational functioning.

Day Treatment:

A modality of substance abuse and/or mental health treatment provided during the day, normally consisting of eight hours.

Dependency:

The tendency to rely overly upon others or a specific substance.

Disease:

An abnormal condition of an organism or part, especially as a consequence of infection, inherent weakness, or environmental stress that impairs the normal physiological functioning.

Family:

Those people, usually a mother, a father, and a child or children, who are dependent on one another for meeting their social, emotional, spiritual, and physical needs. "Family" could be extended to include others who become family members through birth, marriage, or legal adoption.

Statement of Hypotheses

Hypothesis 1. Is there a statistical significant relationship between adolescents of alcoholic parents admitted for substance abuse or dependence and adolescents of non-alcoholic parents?

Hypothesis 2. Is there a statistical significant relationship for both groups concerning divorce of their parents due to alcoholism?

CHAPTER THREE

METHODOLOGY

Research Design

This study is a comparative analysis of two groups of adolescents and one group is identified as adolescents of alcoholics admitted into an alcohol and drug treatment program. The second group is composed of students from Phoenix Program at Carver High School located in Atlanta, Georgia. It is based on a descriptive statistical design utilizing the Pearson R computation to determine the level of significance.

Site and Setting

The researcher, a masters of social work graduate student, in a didactic fashion, assembled five African-American females, three Caucasian females and twelve African-American males in a classroom located on the premises of the Fulton County Adolescent Substance Abuse Day Treatment program, located in Atlanta, Georgia. The second group of students was composed of three Caucasian females, seven African-American females and ten African-American males, all from Phoenix Program at Carver High School, located in Atlanta, Georgia.

The purpose and the nature of the research study was explained to both groups. The instrument was also explained and both groups were asked to best describe their

feelings, behavior and experiences related to alcohol usage. The concept of confidentiality was reiterated, and it was further emphasized that no one would have access to the results of this questionnaire without written parental consent to release this information.

The questionnaire was administered during a November morning at the Fulton County Adolescent Substance Abuse program, starting at 9 A.M. and ending at 10:30 A.M. The classroom furniture was equipped with 40 desks and with a large clock centered to the front of the class, so respondents could keep track of the start and ending time of the test. There were no windows to the classroom. Outside noise was minimal. The room temperature was set at 75 degrees. An identical setting was arranged at Phoenix Program at Carver High School, located in Atlanta, Georgia.

Sample Population

The study utilized a non-probability convenience sample as the treatment group and a randomly selected comparison group. One group was adolescents in clinical substance abuse treatment who had been identified as adolescents of alcoholics. The convenience sample population came from teenagers admitted into The Fulton County Adolescent Substance Abuse Day Treatment program, located in Atlanta, Georgia. The comparison group were adolescents within the same age category from the Phoenix Program at Carver High School, located in Atlanta, Georgia, who had not been previously identified as Adolescents of Alcoholics. Every third student was randomly selected from a pool of 30 students. Both groups were from urban and suburban communities.

Adolescents were admitted into the program based on the following criteria:

1. Male or female adolescents between ages 12 thru 17 years old.
2. Free of any untreated medical condition or infectious disease.
3. Able to care for his or her personal hygiene.
4. Primary diagnosis of substance abuse or early stages of chemical dependency where impairment is minimal and social and family support are intact.
5. No need for detoxification.
6. No major behavioral problems.
7. No evidence of suicidal or homicidal ideation and no major criminal charges.
8. Adolescent and family willing to sign a treatment contract involving rules, attendance, aftercare, and participation in the program.
9. Possess verbal ability to participate in group process.

The Diagnostic Statistical Manual IV was also used to determine criteria for admission based on substance abuse and dependency criteria.

Instrumentation

The screening instrument tool that was used in this research project to identify adolescents of alcoholics was the Children of Alcoholics Screening Test C.A.S.T. This screening instrument is used to psychometrically identify adolescents who are living with or have lived with alcoholic parents. The C.A.S.T. is a valid and reliable 30 item inventory questionnaire that measures adolescent's feelings, attitudes, perceptions, and experiences related to their parent's drinking behavior. This tool can also be used to strengthen the treatment of the alcoholic by using the adolescent's feelings, perceptions, and experiences to confront the alcoholic's denial of drinking-related problems.

The C.A.S.T. was developed by Dr. John W. Jones in 1981 and is used by researchers to identify adolescents of alcoholics, as a clinical counseling tool, and to assist diagnosis of parental alcoholism. It is used in many settings such as hospitals, colleges, high schools, grade schools, courts, and clinics. The items for the questionnaire

were formulated from real-life experiences that were shared by clinically diagnosed adolescents of alcoholics during group therapy and from published case studies.

Data Collection Procedure

The Children of Alcoholics Screening Test is composed of 30 items and the participants either indicated "yes" or "no" to the corresponding questions. The participants were supplied pencils and were given one hour and thirty minutes to answer the 30 questions. All "yes" answers are tabulated to yield a total score. The total score can range from zero to 30.

Data Analysis

Using a Pearson R statistical analysis computed on the date received on the 30 C.A.S.T. items, results reveal if there is a significant difference between adolescents of alcoholics and adolescents from non-alcoholics, control group. It may also show if any of the control group adolescent were "at-risk."

A cutoff score of six or more was found to reliably identify adolescents of alcoholics.

The proposed diagnostic criteria is:

C.A.S.T. SCORE	DIAGNOSIS
0-1	Adolescents of Non-Alcoholics These adolescents most likely have non-alcoholic parents. A score of one might suggest problem drinking.

2 to 5	Adolescents of Problem Drinkers These adolescents have experienced problems due to at least one parent's drinking behavior. These are adolescents of either problem drinkers or possible alcoholics.
6 or more	Adolescents of Alcoholics These are more than likely adolescents of alcoholics. Whether or not the parent is early, middle or late state alcoholic needs to be determined.

When using diagnostic criteria, it is important to keep in mind that some respondents may be motivated to "fake good" on the C.A.S.T. Interpretation must be with caution.

The C.A.S.T. is designed to yield one total score. All "yes" answers are summed to yield a total C.A.S.T. score. This total score can range from zero, no experience with alcohol misuse, to thirty, multiple experiences with parental alcohol abuse.

CHAPTER FOUR

PRESENTATION OF RESULTS

This descriptive statistical design utilizing the Pearson R computation rendered the following results. The frequency distribution results are presented in Appendix H. The sample population (N=39) were drawn from a local Fulton County Adolescent Substance Abuse program, located in Atlanta, Georgia. The comparison group consisted of 7th and 8th graders from Phoenix Program at Carver High School, located in Atlanta Georgia.

The researcher was functioning as a contractual consultant with the Phoenix Program at Carver High School of which respondents were selected. Permission from the following sources were ascertained prior to engaging respondents in the research study. Director of Mental Health/Mental Retardation/Substance Abuse, Principal of Phoenix Program at Carver High School, parental permission forms advising parents regarding the nature of the study, permission signature form, permission to employ the instrument, and informed consent.

Level of Significance

In deciding the probability a .05 level of significance was used. Each table results reflects the likelihood of a particular outcome occurring based on the .05 probability

Arguably, the null hypothesis in this study can be rejected based on the significant found for item fourteen. However, generalization of the results of this research study must be held suspect due to potential Type I error.

Furthermore, several confounding variables were not controlled for which make have had marginal contaminating effect on these results. The level of significance is presented in Tables 1 through Table 30.

Table 1.

Have you ever thought that one of your parents had a drinking problem. **N=39**

	Yes	No	Totals
School	13	5	18
Treatment	17	4	21
Total	30	9	39

$X^2 = 0.141$, df = 1, $p > .05$

A non-directional relationship at 0.141 level of significance, was found between the school group and treatment group. Thirteen respondents from the comparison group answered "yes" as compared to seventeen respondents for the treatment group. However, a mark disparity in frequency scores, 77.9% of both school and treatment groups answered "yes" while 23.1 % answered "no," which suggest that although the adolescents who were not admitted for substance abuse treatment, might indeed, have a parent in the home with a drinking parent. See Appendix H, Table 31.

Table 2.

Did you ever lose sleep because of a parent's drinking. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	8	13	21
Total	19	20	39

$X^2 = 2.055$, df = 1, $p > .05$

An inverse relationship was found between both groups regarding their parent's ability to stop drinking. Eleven school respondents answered "yes" and seven answered "no," as compared to eight treatment group respondents answering "yes" and thirteen respondents answering "no," this indicated a Level of Significance at 2.055. When the frequency distribution was examined as reflected in Table 32, Appendix H, 48.7% of both treatment and school adolescents answered "yes" as compared to 51.2% who answered no. While the percentages suggest that both groups lost equal amount of sleep throughout the night due to a parent's drinking, other environmental variables must be considered with regard to the lost of sleep. Frequency distribution results to this item are found Table 32 in Appendix H.

Table 3.

Do you ever encourage one of your parents to quit drinking. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	12	9	21
Total	23	16	39

$X^2 = 0.063$, df = 1, $p > .05$

A non-directional relationship at the 0.063 level was indicated for respondents of both treatment and comparison groups. Responses were almost identical for both groups. Respondents percentage score reflected an 8% difference in "yes" and "no" responses for both groups. This suggests that adolescents admitted to substance abuse treatment, and those not admitted have encouraged a parent at some point to stop drinking. The frequency distribution is found in Table 33, Appendix H.

Table 4.

Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking. **N=39**

	Yes	No	Totals
School	14	4	18
Treatment	14	7	21
Total	28	11	39

$X^2 = 0.591$, df = 1, $p > .05$

Respondents scores for both groups showed no significance based on the .05 probability in their responses. The Level of Significance, 0.591, for both treatment and comparison groups can be somewhat misleading in that it does not reflect the high percentage 71.8% of "yes" responses as compared to 28.2% "no" responses of adolescents feelings alone, scared, nervous or frustrated due to a parent's perceived inability to stop drinking. Table 34 reflects the frequency distribution Appendix H.

Table 5.

Did you ever argue or fight with a parent when he or she was drinking. **N=39**

	Yes	No	Totals
School	10	8	18
Treatment	12	9	21
Total	22	17	39

$X^2 = 0.0099$, $df = 1$, $p > .0$

There is no significance, 0.0099, between both groups regarding fights with their parents. For both groups, 22, 56.4 percent of respondents answered "yes" and 43.6% answered "no." This suggests that some level of verbal or physical discordance has transpired while a parent was under the influence of alcohol. The initiation of this confrontation is an extraneous variable that must be considered in regard to assessing the drinking parent's volatility. Appendix H reflects the frequency distribution found in Table 35.

Table 6.

Did you ever threaten to run away from home because of a parent's drinking. **N=39**

	Yes	No	Totals
School	13	5	18
Treatment	13	8	21
Total	26	13	39

$X^2 = 0.464$, df = 1, $p > .05$

A non-directional relationship was found for both groups, which also indicates no significance. While no strong significance, 0.464, was found, 66.7% of both groups responded "yes" as compared to 33.3% answered "no." It is possible to infer that adolescents from both groups are leaving home for extended amount of time due to a parent's drinking. Whether this is one day or 10 days is uncertain. Table 36 cites the frequency distribution Appendix H.

Table 7.

Has a parent ever yelled at or hit you or other family members when drinking. **N=39**

	Yes	No	Totals
School	12	6	18
Treatment	12	9	21
Total	24	15	39

$X^2 = 0.371$, df = 1, $p > .05$

A non-directional relationship indicated by respondents in that both groups felt indifferent, which suggest no significance at the 0.371 level. The frequency distribution scores reflect a strong percentage, 61.5%, of adolescents who are engaging in abusive or violence encounters with a drinking parent, as compared to 38.5% who are not. See frequency distribution in Table 37 Appendix H.

Table 8.

Have you ever heard your parents fight when one of them was drunk. **N=39**

	Yes	No	Totals
School	6	12	18
Treatment	10	11	21
Total	16	23	39

$X^2 = 0.818$, df = 1, $p > .05$

No strong level of significance, at the 0.818 level, is indicated by both groups. Both groups responded at almost identical percentage rate, 41.0% and 59.0% said "no," which suggest that both groups have heard fights between their parents at the same rate. Table 38 reflects the frequency distribution see Appendix H.

Table 9

Did you ever protect another family member from a parent who was drinking. **N=39**

	Yes	No	Totals
School	13	5	18
Treatment	14	7	21
Total	27	12	39

$X^2 = 0.140$, df = 1, $p > .05$

A non-directional relationship at the 0.140 level was indicated. Scores are essentially identical for both groups. No significance was found. The margin of percentage differences 69.2% "yes" and 30.8% "no" is consistent with the level of significance found for both groups. Table 39 reflects the frequency distribution. See Appendix H.

Table 10.

Did you ever feel like hiding or emptying a parent's bottle of liquor. **N=39**

	Yes	No	Totals
School	10	8	18
Treatment	13	8	21
Total	23	16	39

$X^2 = 0.161$, df = 1, $p > .05$

No statistical significance, 0.161, found between both treatment and comparison groups. The percentage rate for adolescents admitted in treatment and the comparison group reflects a their concern for the drinking parent. For both school and treatment groups 59.0% answered "yes" and 41.0% answered "no." Table 40 reflects the frequency distribution. See Appendix H.

Table 11.

Did you ever fear that your parents would get divorced due to alcohol misuse. **N=39**

	Yes	No	Totals
School	15	3	18
Treatment	11	10	21
Total	26	13	39

X^2= 4.179*, df = 1, p > .05

Strong significance, 4.179, was indicated by the school and treatment groups. Fifteen students answered "yes" compared to eleven respondents from the treatment group. This level of significance indicates that the treatment or comparison groups are as fearful of their parents getting a divorce as adolescents of alcoholic parents. However, 66.7% different in frequency results is indicated for respondents answering "yes" as compared to 33.4% who said "no." See frequency distribution Table 41 Appendix H.

Table 12.

Did you ever wish that a parent would stop drinking. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	11	10	21
Total	22	17	39

$X^2 = 0.3004$, df = 1, $p > .05$

No significance, 0.3004, was indicated between both groups. Contrary to the level of significance results, a marginal disparity between the respondents who answered "yes" 56.4 and respondents who answered "no" 43.6 was found. This suggest that a over three-fourth of the sample population has a parent who drinks that they wish would stop. See Table 42 for frequency distribution Appendix H.

Table 13.

Did you ever feel responsible for and guilty about a parent's drinking. **N=39**

	Yes	No	Totals
School	9	9	18
Treatment	11	10	21
Total	20	19	39

$X^2 = 0.022$, df = 1, $p > .05$

A non-directional relationship between both groups was found. Scores are near identical. No statistical significance, 0.022, was found. However, 51.3 of sample population answered "yes" as compared to 48.7 who answered "no" to this question. Respondents of both groups have begun to internalize guilt about a problem drinking parent, and struggling with an underpinning feeling of responsibility or blame for the parent's drinking problem. See Table 43 in Appendix H for results of frequency distribution.

Table 14.

Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking. **N=39**

	Yes	No	Totals
School	8	10	18
Treatment	10	11	21
Total	18	21	39

$X^2 = 0.039$, df = 1, $p > .05$

Results do not exceed 1.96 level of significance, 0.039, for a probability of .05 level. The level of significance and frequency distribution scores are consistent in that 46.2 of respondents answered "yes" compared to 53.8 respondents who answered "no." Table 44 reflects the frequency distribution. See Appendix H.

Table 15.

Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem. **N=39**

	Yes	No	Totals
School	12	6	18
Treatment	10	11	21
Total	22	17	39

$X^2 = 1.430$, df = 1, $p > .05$

No statistical significance, 1.430, is found between both groups regarding avoidance of outside activities. Many of the respondents from both groups 56.4% compared to 43.6% are not returning home either after school or sporting event due to a parent's alcoholism. A great deal of shame and embarrassment is blocking their ability to return to home. See Table 45 for results of frequency distribution Appendix H.

Table 16.

Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent. **N=39**

	Yes	No	Totals
School	8	10	18
Treatment	10	11	21
Total	18	21	39

$X^2 = 0.039$, df = 1, $p > .05$

A non-directional relationship as well as no statistical significance, 0.039, is found. Frequency distribution results, however, suggest that adolescents from both groups feel caught in the middle of parental discord. As many 46.2% answered "yes" and 53.8% answered "no." Table 46 reflects the frequency distribution. See Appendix H.

Table 17.

Did you ever feel that you made a parent drink alcohol. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	13	8	21
Total	24	15	39

$X^2 = 0.0025$, df = 1, $p > .05$

A non-directional relationship was found between the two groups at 0.0025 level of significance, and .05 level of probability. However, the study found that 61.5% of both groups responded "yes" as compared to 38.5% of responded "no." Adolescents are feeling the blame for their parent's involvement with drinking as suggested by the percentage results. See Table 47 in Appendix H for frequency distribution results.

Table 18.

Have you ever felt that a problem drinking parent did not really love you. **N=39**

	Yes	No	Totals
School	14	4	18
Treatment	12	9	21
Total	26	13	39

$X^2 = 1.857$, df = 1, $p > .05$

A relationship was found but not considered significance, 1.857, enough to reject the null hypothesis. Frequency distribution results 66.7% of respondents answered "yes" and 33.3% answered "no." These results are consistent in that both group's perception was that the problem drinking parent does not love them or does not manifest this love in a positive manner. See Table 48 for frequency distribution Appendix H.

Table 19.

Did you ever resent a parent's drinking. **N=39**

	Yes	No	Totals
School	9	9	18
Treatment	9	12	21
Total	18	21	39

$X^2 = 0.199$, df = 1, $p > .05$

No relationship was found between adolescents of alcoholic parents and school students. There was no statistical significance, 0.199, found. According to the frequency distribution results, 46.2 of respondents answered "yes" and 53.8% answered "no." There is a small margin between the responses of both groups. This could suggest ambivalence about stating that they resent their parents or ambivalence. Table 49 reflects the frequency distribution Appendix H.

Table 20.

Have you ever worried about a parent's health because of his or her alcohol use. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	11	10	21
Total	22	17	39

$X^2 = 0.300$, df = 1, $p > .05$

Scores do not exceed 1.96 level of significance, 0.300, for .05 probability and therefore insignificant. The frequency distribution results reflect that many of the respondents do not worry about a parent's health as much as their drinking problem. Physical health related problems are not visible most of the time, and do not often concern adolescents. The frequency results reflected this perception. As many as 56.4 % of respondents answered "yes" as compared to 43.6% answered "no." See Table 50 in Appendix H, which reflects that frequency distribution for this item.

Table 21.

Have you ever been blamed for a parent's drinking. **N=39**

	Yes	No	Totals
School	14	4	18
Treatment	16	5	21
Total	30	9	39

$X^2 = 0.014$, df = 1, $p > .05$

A non-directional relationship was found for this item and it had no statistical significance, 0.014. Several items aforementioned alluded to adolescents of both groups feeling the blame for the problem drinking parent. The frequency distribution results are consistent with the other items that found an underpinning feeling of blame for most respondents of both groups. The frequency distribution of 76.9% was found among respondents who answered "yes" and 23.1 who answered "no." See Table 51 in Appendix H for frequency distribution.

Table 22.

Did you ever think your father was an alcoholic. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	7	14	21
Total	18	21	39

$X^2 = 3.009$, df = 1, $p > .05$

An inverse statistical significance, 3.009, relationship is found between both groups. Treatment group scores suggesting that there are strong feelings concerning whether their mothers are an alcoholic. The frequency of 46.2% of respondents answered "yes" and 53.8% answered "no." It is uncertain as the cause for the inconsistency in responses for level of significance and frequency results. It can be hypothesized that some of the respondents felt that they would betray their father by revealing their genuine feeling or perception that they thought he was alcoholic. It could also suggest that respondents really do not feel their father is an alcoholic, particularly, if they have conceptualized the alcoholic as the "Skid Row" type. Table 52 reflects the frequency distribution for this item. See Appendix H.

Table 23.

Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem. **N=39**

	Yes	No	Totals
School	5	13	18
Treatment	3	18	21
Total	8	31	39

$X^2 = 1.082$, $df = 1$, $p > .05$

Although both groups have felt at some point that someone could help a problem drinker in their families, there was statistical insignificance, 1.082, found. However, frequency distribution results suggest that many of the adolescents from both groups have entertained thoughts of wishing their homes were different. A percentage of 20.5% said "yes" and 79.5% said "no." See Table 53 in Appendix H for frequency distribution.

Table 24.

Did a parent ever make promises to you that he or she did not keep because of drinking.
N=39

	Yes	No	Totals
School	7	11	18
Treatment	12	9	21
Total	19	20	39

$X^2 = 1.293$, $df = 1$, $p > .05$

This marginal significance indicates that siblings have fought on some occasions about parental drinking, but significance, 1.293, cannot be generalized to a larger population. A higher frequency result was found for respondents who felt the drinking parent had made unkept promises. A percentage of 48.7% had experienced this type of "let down" while 51.3% answered that they had not experienced unkept promises by the drinking parent. See Table 54 regarding the frequency distribution Appendix H.

Table 25.

Did you ever think your mother was an alcoholic. **N=39**

	Yes	No	Totals
School	10	8	18
Treatment	7	14	21
Total	17	22	39

$X^2 = 1.947$, $df = 1$, $p > .05$

Statistical significance of 1.947 was found for many of the school students who avoid home situations due to parental drinking more than adolescents of alcoholics; this also suggests that screening tools would identify these students as needing some form of intervention, 43.6% answered "yes" and 56.4% answered "no." These results are important in that similiar findings indicated respondents felt that their father was an alcoholic. Again, many confounding variables could be operating with respondents for this particular item. Both groups may have felt revealing "business" about their mother was inconsistent with the family values or unspoken rules of the home. See Table 55 for frequency distribution Appendix H.

Table 26.

Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family. **N=39**

	Yes	No	Totals
School	8	10	18
Treatment	8	13	21
Total	16	23	39

$X^2 = 0.161$, df = 1, $p > .05$

No significance, 0.161, was found regarding physical symptoms resulting from parental drinking. A percentage of 41.0% of both groups wish they had someone to discuss alcohol-related problem with outside the family, while 59.0% felt they did not need anyone to talk too. See Table 56 in Appendix H for frequency distribution.

Table 27.

Did you ever fight with your brother and sisters about a parent's drinking. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	10	11	21
Total	21	18	39

$X^2 = 0.710$, df = 1, $p > .05$

The results of, 0.710, were found statistically insignificant. Both disowned taking responsibility for duties at home at the same rate. An alarming percentage of both groups are engaging in physical and/or verbal confrontation at home a parent's drinking problem. A percentage of 53.8% answered "yes" compared to 46.2% who answered "no." This clearly points to the interdependent nature of family alcoholism in that one parent's drinking has profound affect on the whole family system. See Table 57 for frequency distribution Appendix H.

Table 28.

Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking. **N=39**

	Yes	No	Totals
School	11	7	18
Treatment	14	7	21
Total	25	14	39

$X^2 = 0.13$, $df = 1$, $p > .05$

There is no statistical significance, 0.13, in approach-avoidance response to a parent's drinking problem for both groups. A small disparity in frequency results was indicated. 64.1% answered "yes" as compared to 35.9% who answered "no." Table 58 reflects the frequency distribution for this item. See Appendix H.

Table 29.

Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking. **N=39**

	Yes	No	Totals
School	14	4	18
Treatment	19	2	21
Total	33	6	39

$X^2 = 1.201$, $df = 1$, $p > .05$

While both groups have potentially witnessed their parents fighting, the level of significance does not substantiate that the fights were related to drinking. The frequency distribution results suggest that 84.6% of both groups never complain of physical illnesses due to parental drinking, as compared to 15.4% who have experienced physical symptoms from a parent's drinking problem. See Table 59 for frequency distribution for this item located in Appendix H.

Table 30.

Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem. **N=39**

	Yes	No	Totals
School	15	3	18
Treatment	20	1	21
Total	35	4	39

$X^2 = 1.492$, df = 1, $p > .05$

Marginal significance, 1.492, was found but no strong inferences can be drawn for generalization to other adolescents of alcoholics. Frequency distribution results are consistent with findings for the Level of Significance in that 89.7% of respondents answered "yes" as compared to 10.3% who answered "no." This suggests that structurally the families of both groups' hierarchy is intact and respondents responsibilities at home match their chronological age. See Table 60 for frequency distribution located in Appendix H.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

Adolescents of alcoholics experience a significantly higher rate of alcoholism than the general population and adolescents of alcoholics tend to have other problems at a higher rate than the general population. Moreover, these adolescents do not seem to be able to easily resolve their problems when they become adults. Instead, they carry many of their problems into early and late adulthood and they may transmit many of these problems to others, including their own children.

The Children of Alcoholic Screening Test can be used to: Psychometrically identify adolescents of alcoholics so that they can be taught how to cope with parental alcoholism, aid in the evaluation of parental alcoholism; confront alcoholics and their spouses on how parental alcoholism is harming their adolescent's emotional, physical, and social well being; and study non-clinical samples of adolescent of alcoholics for research purposes.

Since there are over 12 million school age adolescents of alcoholics, and only 5% of these teenagers are ever identified and helped, screening tests such at the C.A.S.T. appear to be necessary. The results of the research study revealed that both groups, treatment and comparison, were not easily identifiable based on the questionnaire. Both groups had similar feelings and experiences with alcoholism in the family.

The comparison group may indeed be living with alcoholism in some form or another or consistently interact with peers, whose parents are actively involved with drugs or alcohol. Fear of parents getting a divorce, item #14, was found most significant between the treatment group. Respondents from the treatment group answered "yes" at higher rate than respondents of the comparison group.

Limitations of the Study

Although the Children of Alcoholics Screening Test is a valid and reliable instrument that can be quickly used to identify large numbers of Adolescent of Alcoholics, research in this area has been limited since most studies conducted to date have examined adolescents of alcoholics in clinical settings. Most adolescents of alcoholics never come into contact with a clinic until they become adult children of alcoholics.

The United States Department of Health and Human Services released a report in 1981 which noted that only five percent of the school-age adolescent of alcoholics in the United States are identified and receive treatment. Two major reasons for adolescents not receiving treatment are parents with acute alcoholism often times forbid their youngsters to seek help and, secondly, sober, recovering parents often deny that their adolescents are adversely affected by the parental alcoholism.

Although the C.A.S.T. measures a diversity of reactions to parental drinking one should not assume psycho-pathology in the adolescent because of alcoholism in the family. While many of these adolescents are "at-risk" to develop alcoholism and other

emotional and behavioral problems there is no definite research to date which clearly delineates adolescents of alcoholics syndrome with inevitable pathology in all such adolescents.

The sample size for this study was not sufficient in terms of inferences from the results being made and generalized to a larger population. Additionally, this study also pointed out that unless control measures are taken for extraneous variables, its ability to be replicated and render sound generalizations will remain suspect.

Concern can be raised about adolescents losing sleep in relation to a parent drinking. This could suggest that the emotional state of some adolescents extends to preoccupation about the state of their parents involvement with alcohol. This loss of sleep, although not statistically significance, was frequent among the treatment group and comparison group.

A frequency of, 71.8%, although not a statistical level of significance, was the finding that adolescents of both groups related feelings alone, angry and frustrated because of a parent's inability to stop drinking. Here again, concern about the emotional health of adolescents in these situations warrant societal attention.

While Table #6 rendered non-directional relationships evidenced by adolescents of both groups threatening to run away, it was clear that that 66.7% had entertained the thought in relation to a parent's drinking. This could indicate instability relative to feelings of security.

The high percentage of , 76.9%, of the adolescents responses to Table #7, in the school and treatment groups indicating that a parent had either yelled at them or a family

member while the parent was drinking conveys some level of discord. However, this can not be a clear indication of family problems.

Hiding or emptying a parent's bottle of liquor in Table #10 received a high percentage of 59.0%, which suggest further preoccupation with parental alcoholism in the home. Table #13 indicated a small percentage margin between the treatment, 51.3% and 48.7% for the comparison group. The adolescents indicated feeling responsible for or guilty about a parent's drinking which suggests adolescents tendency to taking own acceptance of problems of parents that, perhaps, are out of their realm of capabilities.

Suggested Research Directions

The C.A.S.T. allows the researcher to bridge the gap between the clinical and natural setting. Although the C.A.S.T. is a relatively new screening test, other uses for the C.A.S.T. should evolve in the future in helping to diagnose and identify developmental and behavioral problems in adolescents' lives.

The C.A.S.T. is considered a highly valid and reliable screening tool that can discriminate adolescent of alcoholics from the general population of adolescents but future research is needed to further validate the C.A.S.T. and the evaluate its effectiveness in both clinical assessment and treatment situations. Future research can replicate and extend the findings in this study.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Through the knowledge and information gained in using the adolescents of alcoholics screening tool, both lay persons and social workers who work with and concerned about adolescents can increase their understanding of adolescents of alcoholics, aid in the identification and treatment of the alcoholic parent and prevent these "at-risk" teenagers from actualizing future problems. Screening opportunities should be everywhere that social workers practice.

The statistical findings for most items indicate the basis for and arguing the need for assessment tools. Once identified, adolescents of alcoholics can be referred to specialized treatment programs that would help them to better cope with and recover from the adverse impact of parental alcoholism on their lives.

Treatment programs specifically designed for adolescents of alcoholics are starting to evolve. Social workers are in a position to recognize, protect, support and make referrals when necessary. Adolescents of alcoholics have seldom learned the role combinations which mold healthy personalities. It is imperative that social workers have the skills, knowledge and tools to recognize that adolescents of alcoholics presenting problems may indeed be symptomatic of a larger disorder or family problem.

Furthermore, there is still much to learn with regard to the influence of gender and ethnicity on the results os standardize test. African-American adolescents are reluctant to reveal accurate information regarding their family situation, particularly if the evaluator is of the same race. Many have received messages like "don't put the family business in the street." These unspoken messages given to teenagers at an early age can skew results of test significantly if not controlled.

It is suggested that social work practitioners engage in natural observation of respondents in their environments and daily activities, coupled with standardized testing. Regarding alcoholism and African-American adolescents, it is my contention that unethical practice exist when no consideration is given to media influence and focus on minority communities. These communities are often targeted for the procurement and distribution of alcohol, through the use of billboards and other media venues that serve, in many respects, to desensitize residences to the toxic nature of alcoholism and drug abuse.

The strongest statistically significant relationship was found on item #14, and based on the results of this item, social workers and other professionals must begin to pay more attention to the severity, and depth of teenagers' feelings regarding divorce. It is no longer acceptable to dismiss young people as being resilient and able to adapt rather spontaneously to profound changes in the family structure. This study clearly pointed out that teenagers are thinking more about the impact of divorce on their ability to function effectively. While the items presented here did not indicate strong statistical significance, they offered profound clinical significance as to the difficulties and challenges both groups face daily, and specifically illuminated to raise the social worker's awareness.

Items #2, Did you ever lose sleep because of a parent's drinking? Item #15, Have you ever withdrawn and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem? Item # 18, Have you ever felt that a problem drinking parent did not really love you? Item #22, Did you ever think your father was an alcoholic? Item #25, Did you ever think your mother was an alcoholic? Item #30, Did you ever take over chores and duties at home that were usually done by a parent before he or she developed a drinking problem? It is often a challenge to determine the most effective strategy and approach to effectively assess and treat adolescents who harbor developmental and other systemic concerns.

Eric Erikson's developmental theory was discussed extensively earlier in this study to provide the social worker a brief synopsis of the integration of developmental tasks and environmental variables that children, without regard for ethnicity, must successfully attain.[1] It is hoped that this research will expand the important issues raised and point to further implications and directions for future work in the area of direct social work practice with Black adolescents. It is hoped to better understand and provide a meaningful service for adolescents of alcoholics, particularly African-American, as clinicians and social workers struggle with intervention strategies for adolescents of alcoholics because of the multiple disabilities they present, learning disability, emotional disturbance, fetal alcohol or drug syndrome, physical handicap, and ADHD.

Nancy Boyd Franklin's multi-system approach in the conceptualization of

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[1]E. Erikso, Youth Changes and Challenges (Double Day New York: Publish 1963), p. 20-21.

treatment for this special population, for her approach attempts to account for socio-political, diversity and marco influences that also affects the psychological functioning of adolescents of alcoholics.[2] It is hoped that this paper will generate theoretical research for years to come. There is definitely a need for more studies that demonstrate empirical testing in the direct practice of social work, particularly relating to Black and other minority families where alcoholism exists. It would also be gratifying if other social work graduate students expressed an interest in the area of direct social work practice with Black adolescents of alcoholics, and sought to research meaningful dissertations or theses.

The multi-systems approach provides a conceptual framework for integrating different levels of training.[3] It has a broad-based relevancy to many other ethnic groups and many other complex disabilities. Certainly, it would benefit the entire field of direct social work practice with Black adolescents of alcoholics if more social workers researched and published their interest on this topic. It would also further expand the body of literature that currently exist in this area. Finally, this approach raises major implications with regard to planning for ethnically diverse populations and the formulation and implementation of public policy. It speaks clearly to service delivery systems, collectively, affecting the marco level of service delivery systems.

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[2]Nancy Boyd-Franklin, Black Families in Therapy: A Multi-Systems Approach (New York: The Guilford Press, 1989), p. 26-30.

[3]Ibid.

APPENDICES

APPENDIX A

30 September 98

Mrs. Wyeuca Johnson, LCSW
Director of Fulton County
Mental Health/Mental Retardation/Substance Abuse
141 Pryor Street Suite 212
Atlanta, Georgia 30314

Dear Mrs. Johnson:

The enclosed letter is regarding soliciting participants for the partial fulfillment of an advance degree at Clark Atlanta University, where I am a graduate student.

The research data will only be used for the purpose of professional and academic training for me as a graduate student. The information in the research will be shared with the student's advisor and made available for inspection and circulation at the Robert W. Woodruff Library at Clark Atlanta University's campus. It is important to assure you that all persons involved in reading this information are under strict guide to follow all the rules regarding participants' rights and confidentiality.

It is my request to solicit these participants from the Intensive Outpatient Day Treatment Program. Your approval to carry out this study at the Adolescent Day Treatment program will certainly enable me to further contribute to the understanding of adolescent substance abuse and dependency and the direct practice of social work.

Sincerely,

Mr. Ricky R. Wallace, MS, CAC II
MSW Graduate Student
Clark Atlanta University

APPENDIX B

Fulton County Adolescent Substance Abuse Treatment Program
560 Bankhead Highway
(404) 870-3668

15 October 1998

MEMORANDUM OF UNDERSTANDING:

To: Mr. Ricky Wallace, MSW Graduate Student

From: Mr. Clifton Hatcherson, Assistant Director, SA

Subject: Permission to Perform a Graduate Level Research Study

This letter is in response to Mr. Ricky Wallace's request to carry out a research study at the Fulton County Adolescent Substance Abuse Day Treatment program. Permission is granted in accordance with the agency policies and provisions concerning the confidentiality of clients, to include informed consent and parental permission for his or her child to engage in such study.

Mr. Wallace is also bound to provide families information regarding the results of the study, particularly, where it will assist our families in the amelioration of specific needs. This information must be discarded or given to his supervisor upon completion of the study.

cc: Mrs. Carol Randall, ASAP Coordinator
: Mrs. Wyeuca Johnson, Director MH/MR/SA

APPENDIX C

30 September 98

Mr. Thomas Sullivan, Principal
Phoenix Program at Carver High School
1264 Rice Street
Atlanta, Georgia 30349

Dear Mr. Sullivan:

The enclosed letter is regarding soliciting participants for the partial fulfillment of an advance degree at Clark Atlanta University, where I am a graduate student.

The research data will only be used for the purpose of professional and academic training for me as a graduate student. The information in the research will be shared with the student's advisor and made available for inspection and circulation at the Robert W. Woodruff Library at Clark Atlanta University's campus. It is important to assure you that all persons involved in reading this information are under strict guide to follow all the rules regarding participants' rights and confidentiality.

It is my request to solicit these participants from your seventh and eight grade population. Your approval to carry out this study on your campus will certainly enable me to further contribute to the understanding of Adolescent Substance Abuse and Dependency, as well as the direct practice of social work.

Sincerely,

Mr. Ricky R. Wallace, MS, CAC II
MSW Graduate Student
Clark Atlanta University

APPENDIX D

30 September 98

Dear Parent and/or Legal Guardian:

Please be advised that the research that you agreed for your son or daughter to participate in is part of my academic training and professional development. This research can be used specifically for you and family.

I will use this information for the purpose of enhancing my understanding of Adolescents of Alcoholics, as well as to fulfill the partial requirements for an advance degree at Clark Atlanta University.

It shall only be used for the purpose of professional development and to meet the requirements of this graduate degree. The information in the research will be shared with the student's advisor and will be made available for inspection and circulation in accordance with the Robert W. Woodruff Library regulations governing materials of this type.

It is important to assure you that all persons involved in reading this information are under strict guide to follow all the rules regarding participants' rights and confidentiality. The questionnaire consist of 30 questions regarding Adolescents of Alcoholics and your teenager does not have to disclose his or her name or place of residence.

You have the option to withdraw this consent at any time during the course of the research. If you should have any questions or concerns, please feel free to contact me at (404) 762-3638.

Sincerely,

Ricky R. Wallace, MS, CAC II
MSW Graduate Student

APPENDIX E

CLARK ATLANTA UNIVERSITY
PERMISSION FORM

PERMISSION TO PARTICIPATE IN AN ADOLESCENT OF ALCOHOLICS RESEARCH STUDY

This permission form must be signed by the student, parent or legal guardian.

Student:_____Birth date:_____to participate in the research study regarding adolescents of alcoholics at no cost to me or my family.

I further grant permission for information provided by the student (questionnaire or as a result of direct observation) to be used for the study of characteristics among students, and improvement in the service offered. I understand that the person conducting the evaluation and research shall not directly or indirectly identify any student in any report, and shall not disclose names or other identifying information without my authorization.

Parent Signature:_____Date:_____

Witnessed:_____Relationship:_____

APPENDIX F

30 September 98

Mr. John Jones, Ph.D.
Family Recovery Press
St. Paul Companies
385 Washington Street
St. Paul, Minnesota 55102

Dear Dr. Jones:

Please find enclosed a request for permission to use your Children of Alcoholics Screening Test (C.A.S.T.) for research toward the fulfillment of an advance degree at Clark Atlanta University's School of Social Work at Atlanta, Georgia.

Additionally, please submit to me information regarding the standardization of this survey instrument, particularly information pertaining size, characteristics of the population, validity and reliability.

Your approval and assistance in this matter will certainly enhance my knowledge base and understanding of Children of Alcoholics.

Thank You,

Mr. Ricky R. Wallace, MS, CAC II
MSW Graduate Student
Clark Atlanta University

APPENDIX G

CHILDREN OF ALCOHOLICS SCREENING TEST

C.A.S.T. can be used to identify latency age, adolescent, and grown up children of alcoholics. Please check ( ) the answer below that best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "yes" or "no".

Sex:

Male_____**Female**_____**Age**_____

Yes	No	Questions
		1. Have you ever thought that one of your parents a drinking problem?
		2. Have you ever lost sleep because of a parent's drinking?
		3. Did you ever encourage one of your parents to quit drinking?
		4. Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?
		5. Did you ever argue or fight with a parent when he or she was drinking?
		6. Did you ever threaten to runaway from home because of a parent's drinking?
		7. Has a parent ever yelled at or hit you or other family members when drinking?
		8. Have you ever heard your parents fight when one of them was drunk?
		9. Did you ever feel like hiding or emptying a parent's bottle of liquor"?
		10. Did you ever protect another family member from a parent who was drunk?

APPENDIX G - continued

11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?

12. Did you ever wish that a parent would stop drinking?

13. Did you ever feel responsible for and guilty about a parent's drinking?

14. Did you ever fear that your parents would get divorced due to alcohol misuse?

15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?

16. Did you ever feel caught in the middle of an argument or fight between problem drinking parent and your other parent?

17. Did you ever feel that you made a parent drink alcohol?

18. Have you ever felt that a problem drinking parent did not really love you?

19. Did you ever resent a parent's drinking?

20. Have you ever worried about a parent's health because of his or her alcohol use?

21. Have you ever been blamed for a parent's drinking?

22. Did you ever think your father was an alcoholic?

23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?

24. Did a parent ever make promises to you that he or she did not keep because of drinking?

APPENDIX G - continued

25. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?

26. Did you ever think your mother was an alcoholic?

27. Did you ever fight with your brothers and sisters about a parent's drinking?

28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?

29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?

30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

_____TOTAL NUMBER OF "YES" ANSWERS.

Score of 6 or more means that more than likely this adolescent is a child of an alcoholic parent.

APPENDIX H

FREQUENCY DISTRIBUTION RESULTS

Table 31.

Have you ever thought that one of your parents had a drinking problem.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	13 (33.3)	5 (12.8)	18 (46.2)
Treatment	17 (43.6)	4 (10.3)	21 (53.8)
Total	30 (77.9)	9 (23.1)	39 (100)

APPENDIX H - continued

Table 32.

Did you ever lose sleep because of a parent's drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (28.2)	7 (17.9)	18 (46.2)
Treatment	8 (20.5)	13 (33.3)	21 (53.8)
Total	19 (48.7)	20 (51.2)	39 (100)

APPENDIX H - continued

Table 33.

Did you ever encourage one of your parents to quit drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (28.2)	7 (17.9)	18 (46.2)
Treatment	12 (30.8)	9 (23.1)	21 (53.8)
Total	23 (59.0)	16 (41.0)	39 (100)

Table 34.

Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	14 (35.9)	4 (10.3)	18 (46.2)
Treatment	14 (35.9)	7 (17.9)	21 (53.8)
Total	28 (71.8)	11 (28.2)	39 (100)

APPENDIX H - continued

Table 35.

Did you ever argue or fight with a parent when he or she was drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	10 (25.6)	8 (20.6)	18 (46.2)
Treatment	12 (30.8)	9 (23.0)	21 (53.8)
Total	22 (56.4)	17 (43.6)	39 (100)

Table 36.

Did you ever threaten to run away from home because of a parent's drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	13 (33.3)	5 (12.8)	18 (46.1)
Treatment	13 (33.3)	8 (20.6)	21 (53.9)
Total	26 (66.6)	13 (33.4)	39 (100)

APPENDIX H - continued

Table 37.

Has a parent ever yelled at or hit you or other family members when drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	12 (30.8)	6 (15.4)	18 (46.2)
Treatment	12 (30.8)	9 (23.1)	21 (53.8)
Total	24 (61.5)	15 (38.5)	39 (100)

Table 38.

Have you ever heard your parents fight when one of them was drunk.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	6 (15.4)	12 (30.8)	18 (46.2)
Treatment	10 (25.6)	11 (28.2)	21 (53.8)
Total	16 (41.0)	23 (59.0)	39 (100)

APPENDIX H - continued

Table 39.

Did you ever protect another family member from a parent who was drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	13 (33.3)	5 (12.8)	18 (46.2)
Treatment	14 (35.9)	7 (17.9)	21 (53.8)
Total	27 (69.2)	12 (30.8)	39 (100)

Table 40.

Did you ever feel like hiding or emptying a parent's bottle of liquor.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	10 (25.6)	8 (20.5)	18 (46.2)
Treatment	13 (33.3)	8 (20.5)	21 (53.8)
Total	25 (59.0)	16 (41.0)	39 (100)

APPENDIX H - continued

Table 41.

Did you ever fear that your parents would get divorced due to alcohol misuse.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	15 (38.5)	3 (7.7)	18 (46.2)
Treatment	11 (28.2)	10 (25.6)	21 (53.8)
Total	26 (66.7)	13 (33.3)	39 (100)

Table 42.

Did you ever wish that a parent would stop drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (28.2)	7 (17.9)	18 (46.1)
Treatment	11 (28.2)	10 (25.6)	21 (53.9)
Total	22 (56.4)	17 (43.6)	39 (100)

APPENDIX H - continued

Table 43.

Did you ever feel responsible for and guilty about a parent's drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	9 (23.1)	9 (23.1)	18 (46.2)
Treatment	11 (28.2)	10 (25.6)	21 (53.8)
Total	20 (51.3)	19 (48.7)	39 (100)

Table 44.

Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	8 (20.5)	10 (25.6)	18 (46.2)
Treatment	10 (25.6)	11 (28.2)	21 (53.8)
Total	18 (46.2)	21 (53.8)	39 (100)

APPENDIX H - continued

Table 45.

Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	12 (30.8)	6 (15.4)	18 (46.2)
Treatment	10 (25.6)	11 (28.2)	21 (53.8)
Total	22 (56.4)	17 (43.6)	39 (100)

Table 46.

Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	8 (20.5)	10 (25.6)	18 (46.2)
Treatment	10 (25.6)	11 (28.2)	21 (53.8)
Total	18 (46.2)	21 (53.8)	39 (100)

APPENDIX H - continued

Table 47.

Did you ever feel that you made a parent drink alcohol.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (28.2)	7 (17.9)	18 (46.2)
Treatment	13 (33.3)	8 (20.5)	21 (53.8)
Total	4 (61.5)	15 (38.5)	39 (100)

Table 48.

Have you ever felt that a problem drinking parent did not really love you.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	14 (35.9)	4 (10.3)	18 (46.2)
Treatment	12 (30.8)	9 (23.1)	21 (53.8)
Total	26 (66.7)	13 (33.3)	39 (100)

APPENDIX H - continued

Table 49.

Did you ever resent a parent's drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	9 (23.1)	9 (23.1)	18 (46.2)
Treatment	9 (23.1)	12 (30.8)	21 (53.8)
Total	18 (46.2)	21 (53.8)	39 (100)

Table 50.

Have you ever worried about a parent's health because of his or her alcohol use..

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (2.6)	7 (17.9)	18 (46.2)
Treatment	11 (2.6)	10 (25.6)	21 (53.8)
Total	22 (56.4)	17 (43.6)	39 (100)

APPENDIX H - continued

Table 51.

Have you ever been blamed for a parent's drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	14 (35.9)	4 (10.3)	18 (46.2)
Treatment	16 (41.0)	5 (12.8)	21 (53.8)
Total	30 (76.9)	9 (23.1)	39 (100)

Table 52.

Did you ever think your father was an alcoholic.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (28.2)	7 (17.9)	18 (46.2)
Treatment	7 (17.9)	14 (35.9)	21 (53.8)
Total	18 (46.2)	21 (53.8)	39 (100)

APPENDIX H - continued

Table 53.

Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	5 (12.8)	13 (33.3)	18 (46.2)
Treatment	3 (7.7)	18 (46.2)	21 (53.8)
Total	8 (20.5)	31 (79.5)	39 (100)

Table 54.

Did a parent ever make promises to you that he or she did not keep because of drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	7 (17.9)	11 (28.2)	18 (46.2)
Treatment	12 (30.8)	9 (23.1)	21 (53.8)
Total	19 (48.7)	20 (51.3)	39 (100)

APPENDIX H - continued

Table 55.

Did you ever think your mother was an alcoholic.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	10 (25.6)	8 (20.5)	18 (46.2)
Treatment	7 (17.9)	14 (35.9)	21 (53.8)
Total	17 (43.6)	22 (56.4)	39 (100)

Table 56.

Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	8 (20.5)	10 (25.6)	18 (46.2)
Treatment	8 (20.5)	13 (33.3)	21 (53.8)
Total	16 (41.0)	23 (59.0)	39 (100)

APPENDIX H - continued

Table 57.

Did you ever fight with your brothers and sisters about a parent's drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (2.6)	7 (17.9)	18 (46.2)
Treatment	10 (25.6)	11 (28.2)	21 (53.8)
Total	21 (53.8)	18 (46.2)	39 (100)

Table 58.

Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	11 (28.2)	7 (17.9)	18 (46.2)
Treatment	14 (35.9)	7 (17.9)	21 (53.8)
Total	25 (64.1)	14 (35.9)	39 (100)

APPENDIX H - continued

Table 59.

Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	14 (35.9)	4 (10.3)	18 (46.2)
Treatment	19 (48.7)	2 (5.1)	21 (53.8)
Total	33 (84.6)	6 (15.4)	39 (100)

Table 60.

Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem.

	Yes (Percentage)	No (Percentage)	Total (Percentage)
School	15 (38.5)	3 (7.7)	18 (46.2)
Treatment	20 (51.3)	1 (2.6)	21 (53.8)
Total	35 (89.7)	4 (10.3)	39 (100)

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